# Best Practices for Comprehensive Tobacco Control Programs, 2007
# Summary of Panel Review
# December 6, 2006

## Purpose of Meeting

On December 6, 2006, a panel of experts in comprehensive state-wide tobacco control programs was convened in Atlanta, Georgia to review funding models and approaches to estimating state-specific budget recommendations in order to update CDC's *Best Practices for Comprehensive Tobacco Control Programs* (1999). This guidance document provided a blueprint for what program components should be implemented concurrently in a comprehensive tobacco program and provided the formulas for a range of funding to implement these interventions. The 1999 guidance was developed by drawing from the findings of evidence-based analyses of comprehensive state tobacco control programs, expert opinion, and state experiences. At the expert panel meeting in December, 2006, technical consultation was sought from the panel regarding the best available evidence to determine updated cost parameters (and metrics to calculate them) for major components of a comprehensive tobacco control program. The panel reviewed data relevant to potential changes in the 1999 funding recommendations, including state experience and findings on program effectiveness that has emerged since the 1999 *Best Practices* release.

## Summary of Panel Discussions

Following opening remarks by Dr. Matthew McKenna, Director of the Office on Smoking and Health (OSH), brief presentations were given by Dr. Doug Luke, Associate Professor of Community Health, Saint Louis University and Dr. Terry Pechacek, Associate Director for Science, OSH that recapped the findings of the 1999 *Best Practices* and highlighted subsequent research. In sum, since its release, evidence in support of the efficacy of a comprehensive tobacco control program as defined in the 1999 *Best Practices* has continued to accumulate. An evaluation by Saint Louis University of the implementation of *Best Practices* by ten states found that this document provided a good framework for planning tobacco control programs, but the number of categories was somewhat cumbersome to implement and convey easily to decision makers.

Next, Dr. Todd Rogers of the Public Health Institute reviewed the components of and funding formulas for Media Interventions and Cessation Programs as detailed in the 1999 publication. He posed discussion questions to the panelists, who then formed two subgroups to explore these topics in depth, and then reconvened to share their findings.

> **Media Interventions** in coordination with community mobilization efforts were endorsed as highly effective in reducing youth initiation, promoting smoking cessation, and creating tobacco free social norms. Efforts such as media relations, media advocacy, earned or donated media and paid placement of messages and promotions that counter tobacco industry advertising and promotions were all recognized as ways to increase demand for cessation services and to disseminate information on tobacco-related risk and the benefits of tobacco-free environments.

The 1999 per capita funding formula of $1-$3 was viewed as useful in presenting this component to policy makers. It was noted, however, that changes in state population and the increase in cost of living since 1999 would need to be factored in to any update of this component. Further, media purchase costs and complexity of state media markets would need to be considered. For example, states with more complex and costly media markets would require a minimum per capita dollar amount that is closer to the median of the 1999 funding range. Additionally, it was recognized that production costs to maintain fresh and locally relevant messages could significantly influence program costs, and that the technical aspects of delivering messages and promotions efficiently and effectively to target specific audiences (e.g., by age or race/ethnicity) is evolving rapidly.

**Cessation Programs** was seen as an inappropriate label for this category as it may be interpreted as limiting initiatives to group- and individual-level services. Rather, a title such as "Cessation Interventions" might be more appropriate, which would include cessation activities in coordination with increasing the price of tobacco products, smoke-free policies, and media campaigns. The discussion emphasized that such cessation-related interventions had strong evidence of efficacy that justifies increasing the proportion of smokers participating in these services. Cessation interventions should build upon a foundation of system-based initiatives to ensure that all tobacco users seen in the healthcare system are screened, that they receive brief advice to quit, and that they are offered more intensive counseling services and FDA-approved medication. Additionally, use of proactive quitline counseling services could be expanded given their availability nationwide and their proven efficacy in increasing cessation rates. The discussion of recent state experience suggests that at the lower-bound end of funding it would be beneficial to provide two weeks of nicotine replacement medication to all quitline callers who also receive counseling. State experience also suggests that with higher funding levels callers who receive telephone counseling that meet a state's criteria (such as Medicaid recipients, uninsured, or insured but without coverage for cessation pharmacotherapy) could receive an additional benefit of a full course of FDA-approved nicotine replacement medication.

The Panel viewed the variables in the 1999 funding formula (per capita-based allocations for healthcare system changes and operation of a quitline) as consistent with the current program guidance. It was noted, however, that a minimum cost estimate based on approximately 1% reach for a quitline, as budgeted in the 1999 funding formula, was low compared to what states are currently able to attain. A more appropriate funding minimum might be based upon a 5% reach, with the upper-bound funding estimate based upon reaching 10% of smokers in the state each year. Changes in state population as well as the number of smokers in the state and the increase in cost of living would also need to be factored in to a current cost estimate. Additional funds would also be needed to account for the current cost of providing proactive quitline counseling services and FDA-approved medication.

Following these breakout sessions, Dr. Rogers reviewed the remaining intervention categories, presenting them in two collapsed categories: Community Interventions and Youth Programs.

Again, he posed discussion questions to the Panel, who then formed two subgroups to explore these topics in depth and reconvened to share their findings.

**Community Interventions** was presented as a combination of the previously labeled Community Programs, Statewide Programs, and Tobacco-related Disease Programs categories. The Panel found this organizational change to be easier for presenting the information to decision makers. Discussion among the Panel also supported incorporating the Youth component (a consolidation of School Programs and aspects of Enforcement, as described below) into Community Interventions as well. All of these interventions, implemented at the local level to influence societal organizations; systems; and networks to support tobacco-free norms, were considered to be the foundation of state-wide programs.

It was recognized that while funding was included in the 1999 *Best Practices* guideline for the purpose of identifying and eliminating tobacco-related disparities, updated materials would need to be more explicit in providing programmatic guidance on this issue. The Panel saw continued funding of disparities-related activities within this component as essential.

The 1999 funding formulas for these categories which include fixed costs for infrastructure, training, and technical assistance plus per capita allocations for programming were supported by the Panel. In addition to combining these funding lines into Community Interventions, changes in state population and the increase in cost of living since 1999 would need to be factored in to this estimate.

**Youth Programs** was presented as a new category that included the previously labeled School Programs and Enforcement. There was discussion about removing "Programs" from the title as there should be more focus on integration with other community activities. Youth programs and school-based interventions were recognized as part of a comprehensive intervention but only if implemented in coordination across the community and school environments and in conjunction with increasing the price of tobacco products, media campaigns, smoke-free environments, and other efforts to create tobacco-free social norms. In both the breakout and the larger group there was discussion about combining the funding for School Programs with the broader Community Interventions component. Because Enforcement includes youth-specific activities such as monitoring youth access to tobacco and retailer compliance as well as more general policy issues such as smoke-free environments, there was discussion about folding some aspects of Enforcement in with Community Interventions and other aspects in a State-level Coordination-type infrastructure category.

The 1999 funding formula for School Programs, based on student per capita plus a base amount, was seen as useful, but it was noted that program implementation may need to shift to more of a focus on school-based tobacco-free policies, youth mobilization efforts, and coordination with media and community interventions. The 1999 funding formula for Enforcement, which includes a base amount for training and interagency coordination plus a per capita amount for the number and type of outlets requiring compliance checks,

also retained relevance, but would require review if aspects of the component are re-categorized. In addition to changes in state population and cost of living increases, changes in the number of schools, the number of K-12 grade students, and the number of establishments subject to tobacco-related policy might also be factors to consider in an updated estimate.

Following the breakout groups and full group recaps, there was general discussion about the infrastructure needs for comprehensive programs. Of note:

**Surveillance and Evaluation** was viewed as critical to ensure program accountability and to inform strategic planning. The 1999 formula of 10% of overall program implementation costs was still considered sound, but more funds may be required for development of effective local capacity for evaluation and more detailed evaluation of media, cessation, and community interventions.

**Administration and Management** is necessary for monitoring grants and contracts and supervising program implementation to ensure accountability. However, because of the difficulties faced by multiple states to maintain adequate funding for this component, there was discussion about folding it into the Community Interventions line. Conversely, because it is so important, there was also discussion about keeping it as a separate line item and expanding the description to also reflect the value of interagency coordination and policy efforts.

Another option considered was to include interagency coordination and policy functions within a proposed new State-Level Coordination component.

The 1999 formula of 5% of overall program implementation costs was still considered sound, but more funds, perhaps as much as 7% of the overall program, may be required for increased efforts to reduce disparities, and interagency coordination. This funding would also enable coordination across program components and across local programs.

**State-Level Coordination** of program components and partnerships, supporting community coalitions, state-level policy efforts, and facilitating strategic planning and policy initiatives was viewed as central to an effective comprehensive program effort. There was discussion about creating a new funding component that would bring in aspects of Administration and Management and Enforcement. The state-level coordination of aspects of several other 1999 components now combined within the broader Community Intervention component (such as tobacco-related disease programs, school programs, and initiatives to eliminate disparities) would also be addressed within this component.

Funding formulas would be recalculated to account for this shift in how funds are distributed. Both fixed costs and population-based parameters were seen as important variables in developing a funding formula for this category.

**General Discussion**

Based upon the review of current evidence and group discussions, there was general agreement that the 1999 guidance remained sound but could be updated in some specific ways. Changes might include a reduction in the number of program components in which the funding guidelines would be presented as well as adjustments in component funding formulas to reflect new science and account for shifts in the population and cost of living changes.

**Next Steps**

The need for continued and more detailed discussions of each program component was recognized. There was discussion about the need for guidance to states on how to best determine where in the recommended range of funding they belong. There was a discussion about the timing and most appropriate format of the revision; various alternative approaches were considered.